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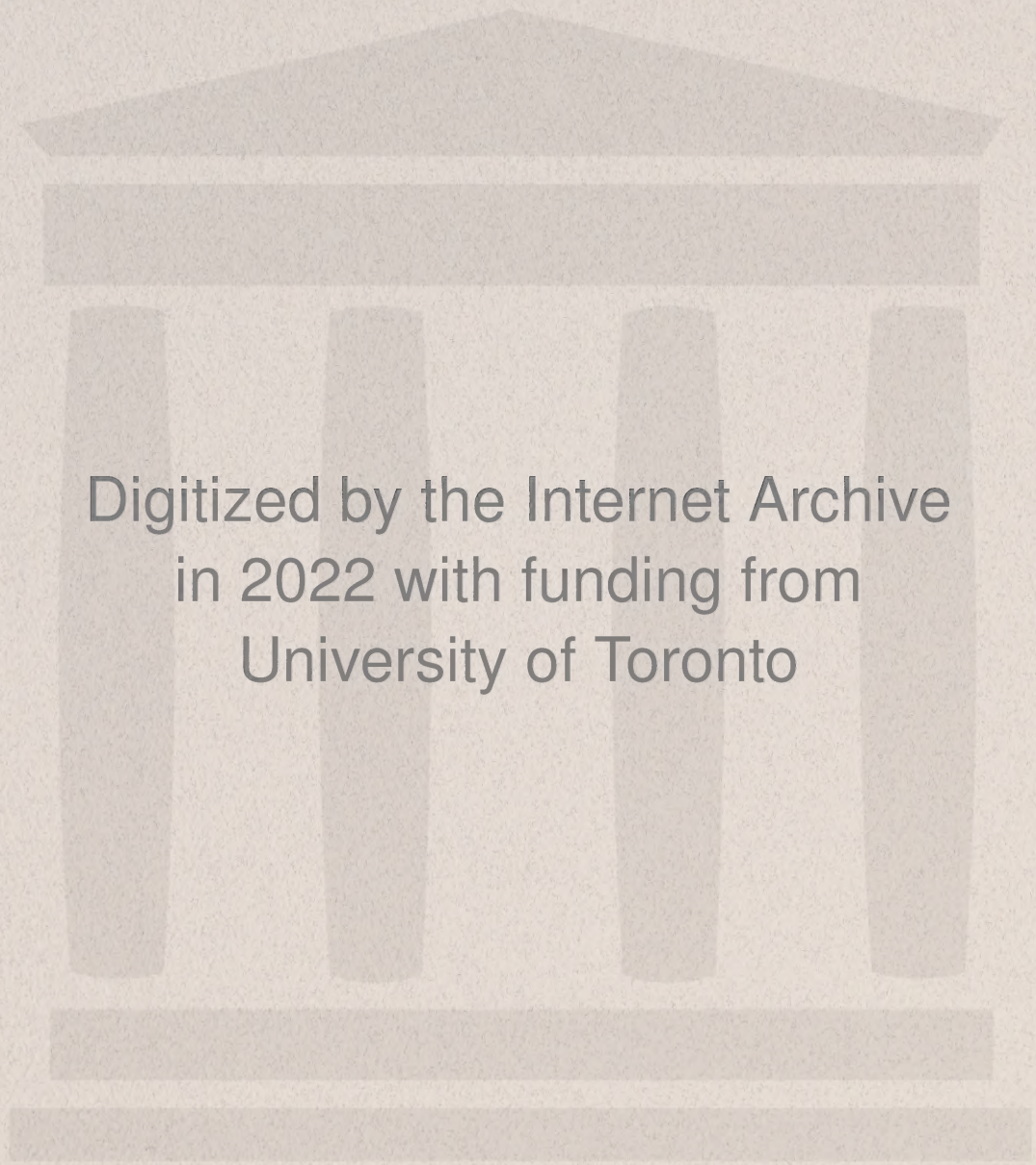

STANDING COMMITTEE ON
PUBLIC ACCOUNTS

Ontario
LEGISLATIVE ASSEMBLY
ASSEMBLÉE LÉGISLATIVE

TORONTO, ONTARIO
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The Honourable David Warner, M.P.P.,
Speaker of the Legislative Assembly.

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Remo Mancini, M.P.P.
Chair

Queen's Park
June 1992

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REPORT ON THE AUDIT REPORT ON OUT OF PROVINCE OHIP PAYMENTS PROVIDER SERVICES BRANCH, MINISTRY OF HEALTH

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Clerk of the Committee

Ray McLellan
Research Officer

***to 20 December 1991**
****from 20 December 1991**

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PREAMBLE

The Provincial Auditor's report on out-of-province OHIP payments by the Ministry of Health (s. 3.13, 1990 Annual Report) was considered by the Standing Committee on Public Accounts during the period June - December, 1991. The Members were concerned specifically with one aspect of the Auditor's report, namely the subject of out-of-province payments for substance abuse patients. The Committee held hearings at Queen's Park and visited ten substance abuse treatment facilities, five in Ontario and five in the United States.

The witnesses at Queen's Park included representatives from the Ministry of Health, Ministry of Correctional Services, the Task Group on the Advisory Committee Report on Drug Treatment, Bellwood Health Services Inc., the Addiction Research Foundation, the Donwood Institute, and Portage Ontario. The Committee met with the Chair of the Parliamentary Assistants' Task Group to discuss the public consultation process on the report, "Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's".

The Committee would like to extend its gratitude to the treatment facilities visited in Ontario and the U.S. and to acknowledge their important contribution to this investigation. The Committee's visits to these centres were essential, as they afforded Members the opportunity to witness and discuss the challenges which confront professionals on a daily basis, in the treatment of substance abuse patients. This part of the audit review process was necessary to appreciate and understand the complexity of the rehabilitative challenge.

Furthermore, the Committee would like to thank the witnesses that appeared at Queen's Park and to acknowledge receipt of the supplementary documentation in response to the Committee's requests. This material has been useful in the Committee's deliberations and in the preparation of recommendations.

The Members would like to acknowledge the assistance provided by the Office of the Provincial Auditor, the Committee Clerk, and the Legislative Research Service in the investigation. This Report was prepared by the Legislative Research Service, pursuant to the instructions of the Standing Committee on Public Accounts.

INTRODUCTION

This report addresses out-of-province OHIP payments and specifically the drug and alcohol addiction component as reported in the 1990 Annual Report, Office of the Provincial Auditor. The role and cost of U.S. facilities in the treatment of Ontario patients was a primary concern in the audit report.

The Committee's main objective in this report was to contribute to the understanding of substance abuse and to offer constructive suggestions to assist the Ontario treatment system. During the Committee's investigation, the Ministry of Health introduced new policies on out-of-province treatment which have been taken into account.

The Committee addressed three main questions: Why did Ontario substance abuse patients pursue treatment out-of-province, primarily in the U.S.? What steps have been taken to address the dependence on expensive treatment facilities out of Ontario? and What is required to ensure that the Ontario substance abuse treatment system is able to meet future demand?

The Committee stressed that in addition to the value-for-money concerns of the Standing Committee on Public Accounts, obtaining the best treatment for patients is of paramount importance. The former Chair of the Committee offered the following words on the seriousness of the substance abuse problem:

> This is an issue that obviously every Member of this Committee realizes has been with us for a long time. It is getting worse. It is adding to the cost of running this province. . .

During the investigation the Committee considered information not discussed in the audit report. The Members felt that this was warranted to gain an understanding of the reasons for the out-of-province OHIP payments and the factors to be considered in an assessment of the Ontario treatment system.

Audit Report, Office of the Provincial Auditor

The Provincial Auditor's objective was to assess the adequacy of the Provider Services Branch's monitoring procedures for OHIP billings. The Provider Services Branch was established to perform the following functions, as explained in the audit report:

- monitor billings made by doctors and other practitioners and act as the initial adjudicator in fee disputes;
- monitor payments made to other provinces and countries for health care provided to Ontario residents; and
- control over-utilization of the OHIP system.

According to the audit report, " . . . the Branch was adequately monitoring OHIP billings;" and on out-of-province payments " . . . the Ministry was developing measures to prevent abuse of the provisions for out-of-province treatment of Ontario residents." Nevertheless, the Auditor pointed out that " . . . there were conditions inherent in the system [OHIP] that reduced the effectiveness of monitoring procedures."

The Auditor's report offered the following commentary on the control and cost of out-of-province OHIP payments, prior to the policy changes introduced in 1991:

> *When Ontario residents travel outside the Province, they continue to be covered by OHIP. The coverage is 100 per cent for emergency care and 75 per cent for non-emergency treatment.*
>
> *For the 1990 fiscal year, $120 million was paid to various health care institutions and professionals outside the Province. Non-emergency care accounted for $48 million or 40 per cent, up from 30 per cent three years earlier. Approximately 90 per cent of the payments were made to facilities in the United States.*
>
> *The Branch was concerned that some out-of-province claims had been inflated. It investigated*

claims for non-emergency heart-related treatment in the U.S. and found that amounts billed from Michigan hospitals were significantly above those of other states for comparable treatment. The Michigan average was $25,000 compared to approximately $20,000 for other states submitting billings for similar treatment.

The Branch suspected that some Michigan hospitals had been inflating their costs for Ontario patients so Ontario's 75 per cent payment would cover their full cost.

In 1990, treatment of drug and alcohol addiction accounted for $20 million, up from $7 million in 1989. The public's perception of the lack of treatment facilities for drug and alcohol abuse in Ontario was the major reason for patients going to the U.S. However, the Branch was concerned that U.S. hospitals were luring patients from Ontario. Selling aspects used in recruiting patients included paying their air fare to and from a U.S. hospital and limousine service to and from the airport.

At the time of our audit, the Ministry had delayed payment on approximately $500,000 in claims from U.S. hospitals. It suspected that costs had been inflated and that the claims were generated by individuals or organizations on behalf of patients recruited for treatment in the U.S.

We were informed that the Ministry was planning measures to prevent this situation from recurring.

In September 1990 the Deputy Minister of Health responded to the Auditor's findings on out-of-province payments:

> The policy framework for the coverage of out-of-country health benefits is currently under review recognizing that there has been a recent upward trend in the provision of insured health benefits for elective procedures.
>
> The Ministry is continuing to monitor service utilization patterns. It is anticipated that the review

process will be completed for implementation in 1991.

Ministry of Health Policy Initiatives (1991)

During 1991 the Ministry of Health released a series of policy statements on the management of the health care system and specifically out-of-country medical treatment. The new policies have been a major consideration in determining the focus for this report and in the preparation of the recommendations.

An April 29, 1991 "News Release", issued by the Ministry of Treasury and Economics in conjunction with the 1991 Budget, announced changes to the health care system, as follows:

> The Government also will enact a series of modifications to the current OHIP policy for out-of-country health services reimbursement rates. Payments for most out-of-country health care services will now be paid according to the cost of comparable services in Ontario.
>
> Out-of-country health care costs, primarily received in the United States, have increased dramatically from $100 million in 1988-89 to $225 million in 1990-91, a 125 per cent increase in only three years.
>
> Under the reforms, payments for emergency and elective services will equal the Ontario per diem rates for hospital care and the equivalent OHIP rate for medical services. Prior approval by the Ministry of Health will be required for payment of unavailable services or those not available in a timely manner in Ontario. The rate of reimbursement will be established by the Ministry of Health.
>
> "We will continue to provide coverage for those services not available in Ontario," the Treasurer said. "However, it is simply not fiscally responsible

> to pay higher rates to American hospitals when the same service is available here in a timely manner."
>
> The cost of these services, which are most often in the area of cardiac care, brain injury treatment, and alcohol and drug rehabilitation are on average more expensive in U.S. health care facilities.
>
> [The Treasurer, Mr.] Laughren said recent and proposed capacity expansions for the most used out-of-country services have reduced the need to seek services outside Ontario. For example, the Government will spend an additional $8.4 million in 1991-92 to expand alcohol and drug treatment programs.

Subsequent "News Releases" from the Ministry of Health on May 2, August 15, September 25 and October 31, 1991 elaborated on the initial statement by the Treasurer. The Minister of Health announced that " . . . the rates paid by the Ontario Health Insurance Plan (OHIP) for hospital treatment outside Canada will be amended to reflect the rates in Ontario." The rate for rehabilitative and less medically intense care, such as the treatment for substance abuse, was set at $200 per day for out-of-country services, effective October 1, 1991. The Ministry explained that the full cost of out-of-country hospital treatment would be covered under limited circumstances and that physicians can apply through a prior approval process for full coverage.

In September 1991, the Ministry of Health outlined new funding for alcohol and drug addiction treatment in Ontario. The expansion program included a registry of addiction services, assessment and referral centres, detoxification centres and a mixture of residential and non-residential programs. Furthermore, a guideline was established for out-of-country addiction treatment as follows:

> As of October 1, [1991] provincial health insurance will cover the full cost of out-of-country addiction treatment only when appropriate care in Ontario is unavailable and when prior approval has been obtained. Those who must go outside the province for treatment will be directed to centres with which

the Ministry of Health has negotiated a payment schedule.

On October 31, 1991 the Ministry of Health released a public consultation paper, "Redirection of Long-Term Care and Support Services in Ontario." The Program objectives include:

- an integrated approach to provincial management of all long-term health care and social services;
- a large expansion in funding for community support services;
- better coordination of services;
- assurance of greater community participation;
- re-alignment of funding policies to reduce regional disparities; and
- increased funding for supportive housing.

The current plan is directed primarily at the elderly and people with disabilities. However, the structural improvements, for example, the coordination of services and an integrated approach across ministries, may benefit other parts of the health care system from a management perspective.

Committee's Terms of Reference

The Committee's investigation began with a review of the Auditor's report on out-of-province payments. It has not been the Committee's intention to assess the treatment models and various programs in use in Ontario and the U.S. as they have been the subject of study by other groups. Although the Committee's primary objective was to consider and report on the Auditor's findings, the investigation has resulted also in recommendations to address problems in the Ontario system.

The Committee's terms of reference for the investigation include the following main topics:

- hearings with the relevant authorities in the field of substance abuse treatment in Ontario, to include the Ministry of Health, Addiction Research Foundation, etc.;

- visits to U.S. and Ontario treatment facilities for comparative purposes to discuss costs and the programs;

- the coordination of the Committee's review with other bodies studying this issue, such as the Task Group on the Advisory Committee Report on Drug Treatment;

- a review of recent provincial policy initiatives on out-of-province OHIP payments; and

- the formulation of recommendations on management and service delivery in the Ontario "treatment system".

The Members are in agreement that there is a need for a strategic review to define program needs and to improve the management of the treatment system in Ontario.

OUT-OF-PROVINCE PAYMENTS

The Ministry of Health addressed out-of-province OHIP payments in relation to total costs, the capacity of institutional and non-institutional programs in Ontario and the number of Ontario patients treated annually in Ontario and in the U.S. The Ministry explained to the Committee the initial steps taken to deter patients from seeking treatment in the U.S. which included the doubling of the treatment system programs in Ontario and a new OHIP policy for treatment in the U.S. to limit payment to 75 percent of the total cost.

The Ministry stated that the escalation of the marketing approach used by U.S. clinics attracted Ontario patients. The Ministry noted that changes to private U.S. medical insurance plans had contributed to the low occupancy rates in the U.S. treatment facilities and that some of these clinics decided to pursue new markets through branch offices in Ontario, for example. The Ministry offered the following comments on this problem:

> So although we were treating 60,000 to 70,000 patients in Canada, and when our own assessments demonstrated that specific need for services in the United States that were not available would account for about 1% or 1.5% of need, patients without assessment, who could go directly to the United States in response to that marketing process, accounted for about 5% of our patient volume but a lot higher than 5% of our costs, because of the costs of American residential drug treatment. The 75% payment policy, which we thought would be a deterrent, turned out to be subverted by the Americans' charging practices, in which they tended to forgive the 25% for reasons that became apparent later on in the course of the subsequent 18 to 24 months as we began to follow how quickly and rapidly this phenomenon unfolded.

In response to the problem of patients going to the U.S., the Ministry conducted two types of audits. One addressed the financial part of the invoices to ensure that payment was for medical treatment and the medical audit verified the necessity of medical services billed to OHIP.

The direct marketing approach, according to the Ministry, resulted in a high response by patients to pursue treatment in the U.S. Also, the U.S. offered liberal admission criteria. The Ministry commented on its statistics and research on referrals, as follows:

> The assessment referral centres saw 16,000 people in the province last year [1990] and, of those, they found that only 18% needed residential care. Of that total, only 1.4% were referred to U.S. services.
>
> They did a survey of their programs for the period between April and October 1990 and found that out of 5,000 people who would have been assessed during that period across the province, only 69 people were referred to the United States.
>
> They have identified that one of the problems people face is the assumption that you need residential treatment if you have an addiction problem. The literature suggests you do not, and they have

> suggested one of the things the ministry should be doing in the years ahead is trying to map a public education program to deflate the myth that residential treatment is the only cure for an addiction problem.

The Addiction Research Foundation (ARF) identified two important issues in the referral process namely, the lack of services in Ontario and U.S. marketing:

> . . . the problem of United States treatment referrals has two major components: one is that there is a lack of services in Ontario, which creates a need to look elsewhere for services; two, we have very aggressive marketing of treatment services in this province, based on the opportunities available within the current context of OHIP regulations.

ARF explained that there has been a growing recognition in the U.S. that residential treatment is not the most cost-effective way to treat substance abuse and that U.S. insurers have been reluctant to fund such programs. Therefore, as discussed by the Ministry, the vacancy rate has become a problem in some U.S. facilities.

ARF offered the following analysis of the relative expense to Ontario of treating a small number of patients in the U.S.

> For example, if one takes into account that there are approximately 217 programs in Ontario that treat individuals with alcohol and drug problems, which are funded to the tune of roughly $77 million, the cost of $40 million to treat 3,400 people amounts to something less than 5% of the cases absorbing more than 30% of the total cost of treatment. The $77 million spent in Ontario is the amount involved in the treatment of the 60,000-plus Ontario residents who are making use of Ontario services versus $40 million for the 3,400 individuals who are making use of U.S. treatment services. So we have to be very conscious that the way this problem is spilling over, in terms of the absence of adequate capacity for treatment here, is at considerable expense.

The Donwood Institute commented that the main advantage has been the capacity in U.S. facilities to accept patients. However, they stated that " . . . in our view, [there is] no doubt that the treatment community in Ontario can deliver programming more effectively and at a fraction of the cost of the American programs."

ANTI-DRUG STRATEGY REPORTS

During the Committee's investigation, the Members considered two reports prepared for the Provincial Anti-Drug Strategy Secretariat. The Secretariat's mandate is to coordinate and implement a strategy with the objective of reducing substance abuse through prevention, treatment and enforcement. The reports of primary interest to the Committee in its review were "Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's", submitted by the Advisory Committee on Drug Treatment in October 1990 and "Caring for Each Other: The People of Ontario Respond to Alcohol and Drug Treatment Problems," submitted by the Parliamentary Assistants' Task Group.

This section of the Committee's report addresses aspects of these studies which are relevant to the audit report directly and generally the improvement of the Ontario treatment system.

Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's

"A Vision for the 90's" includes guiding principles which have a management and treatment orientation to assist in the development of an improved service delivery system for a comprehensive range of treatment programs. The proposed approach was summarized as follows:

> In Ontario, most of the treatment for drug and alcohol problems occurs within the addictions-specific treatment system, which is a system of services developed specifically for people with such problems. In our vision, we propose an increased

> emphasis on services for alcohol and drug problems delivered outside of this system, that is, within the variety of health care, correctional, and social service contexts in which the problems most typically emerge, can be most readily identified, or can be most efficiently treated.
>
> Two distinct approaches would characterize this shift in emphasis. One would involve early interventions in settings, such as schools, where the opportunity exists to identify developing drug and alcohol problems. The other would consist of specialized services for individuals with drug and alcohol problems located in service settings, such as youth services, correctional settings and general hospitals, where these problems are commonly observed.
>
> A continued emphasis on specialization and addictions-specific services is intended. Our vision also includes a coordinated and accessible addictions-specific system of demonstrated high quality and cost-effective treatment. We endorse the importance of multiple treatment options and recommend the development or establishment of more multi-functional services in which a variety of services are provided. We call for a substantial shift in emphasis toward more cost-effective outpatient approaches.

"A Vision for the 90's" addressed numerous aspects of the treatment system in thirty recommendations. The number of referrals to U.S. treatment facilities was viewed as "a major problem". The Advisory Committee summarized its position on this problem, as follows:

> Over the past few years there has been a rapid escalation in the rate of referrals to the U.S. for treatment, fuelled, primarily, by a shortage of services in Ontario and the aggressive marketing by private, for-profit American facilities. The magnitude of these referrals has reached an annual rate of $40 million. This de-facto expansion of treatment services is totally in the form of hospital-based, residential treatment and, as such, is completely at odds with current provincial policy,

> research evidence from the field, and certainly with the vision we propose.
>
> The [Advisory] Committee wishes to assert, in the strongest terms, its conviction that a climate which permits the uncontrolled expansion of the most expensive form of treatment available is incompatible with the methodical, rational development of a comprehensive and cost-effective treatment system in Ontario.
>
> Other provinces severely restrict reimbursement for treatment in the U.S., either by prohibiting it altogether or by allowing it only in rare and unusual circumstances, subject to prior review and approval. The Committee believes that Ontario should do the same. There should be severe restrictions on the circumstances under which reimbursement for U.S. treatment may occur. However, these restrictions will have to be phased in to coincide with the increased availability of treatment alternatives in Ontario.

The Advisory Committee's report recommended that the following steps should be taken to address the out-of-country OHIP payments.

> Recommendation III
>
> a) The Committee [Advisory Committee on Drug Treatment] recommends the amendment of Section 57, regulation 452 of the Health Insurance Act to permit the imposition of severe restrictions on OHIP reimbursement for treatment of alcohol and drug problems in the U.S.
>
> b) The Committee also recommends the redirection of funds currently spent on U.S. treatment to the expansion and development of cost-effective services in Ontario.
>
> c) We further recommend that the imposition of these restrictions be phased in to coincide with the expansion of Ontario services.

Caring for Each Other: The People of Ontario Respond to Alcohol and Drug Treatment Problems

In February 1991 the Task Group of Parliamentary Assistants began the public consultation process on the report, "Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's". The Task Group's report, "Caring for Each Other: The People of Ontario Respond to Alcohol and Drug Treatment Problems" was submitted to the Minister Responsible for the Anti-Drug Strategy in November 1991.

The Standing Committee on Public Accounts reviewed the Task Group's report and met with the Chair of the Task Group on two occasions, in June and December 1991. The discussions addressed the work of the Task Group in relation to the Auditor's report and future treatment options for Ontario.

The Task Group reached the following conclusion on Recommendation No. III of the Advisory Committee, on out-of-country OHIP spending:

> This recommendation received almost unanimous support from presenters before the Task Group.
>
> People were angry that millions of dollars are being spent in the United States for treatment of alcohol and drug problems of Ontario residents. They questioned the aggressive marketing techniques of some U.S. treatment facilities. They also questioned the ethics of referral agencies here in Canada and suggested that severe restrictions, or even a ban, be placed on the referral agencies that receive "head hunter" fees, which can range from $100 to $3,000 per person.
>
> Throughout the province presenters urged that access to U.S. treatment not be shut off before there is adequate expansion of Ontario services to meet urgent and immediate needs for treatment.
>
> Access to out-of-province treatment should be managed on the basis of availability of services in Ontario, urgency of assessed need, and geographic

> accessibility. For example, Fort Frances in northwestern Ontario is located a considerable distance from treatment facilities within the province, but is minutes from a treatment centre located across the border in International Falls, Minnesota. The unique needs of northern and rural communities must be addressed when considering access to out-of-province treatment and the expansion of services in Ontario.
>
> Funding similar to the Northern Travel Grant for medical care should be made available to those needing treatment for addiction.
>
> Presenters agreed that current payment for treatment in the U.S. should be used to expand alcohol and drug treatment facilities in Ontario.
>
> Funds should be directed toward achieving a full spectrum of treatment, allowing flexibility for innovation and experimentation in treatment approaches which would reach particular groups or deal with unique situations.
>
> Standardized, comprehensive assessments would ensure that referrals to out-of-province facilities are appropriate, made by professionals trained in assessment and referral, or by doctors who have specific expertise in the area of addictions.

The Chair of the Task Group pointed out at the December 1991 meeting that the Advisory Committee's report ("A Vision for the 90's") and the Task Group's report ("Caring for Each Other") are the official blueprint for the province's new policy direction on substance abuse treatment. The Chair of the Task Group explained that through the public consultation process the general response to the recommendations in "A Vision for the 90's" was as follows:

> You will know that this report ["Caring for Each Other"] talks about what the "Vision for the 90's" recommends . . . In most of the recommendations, if not all of them, the public and the experts agree totally with the "Vision for the 90's."

VISITS TO ONTARIO AND U.S. TREATMENT FACILITIES

The Standing Committee on Public Accounts visited ten treatment facilities, five in Ontario and five in the U.S. in its review of the audit report. The Committee visited the institutions for comparative purposes and not to conduct an assessment of the treatment programs and models used at the various facilities. The Members were of the opinion that to comment in a meaningful way on the audit report, it would be necessary to discuss the Auditor's conclusions with professionals in Ontario and U.S. treatment facilities to appreciate and understand the various systems. This section of the report summarizes the Ontario and U.S. visits.

The Ministry of Health commented on the U.S. treatment system at the hearing on June 6, 1991, as follows:

> . . . There have been a number of reviews carried out comparing substance abuse treatment facilities in Canada and the United States for alcohol and illicit drugs. One of the reviews was carried out by the Addiction Research Foundation in 1985. On balance and in general there is little difference between residential treatment programs available in the United States and those available here. Ours seem to have more professionals working in them than those in the United States . . .
>
> In terms of the efficacy of treatment programs, however, the comments I made before this committee in 1988 were as relevant then as they are today. That had to do with the limited necessity for residential treatment and the overwhelming applicability and superiority of non-residential alcohol and drug treatment, in terms of the broader base of population that can be served in this way, in terms of the cost-effectiveness of providing such treatment and in terms of the long-term success rates.

Visits to Ontario Facilities

The Committee selected five treatment centres to visit in close proximity to Queen's Park. The Donwood Institute and Bellwood Health Services Inc. also met with the Committee in hearings at Queen's Park. The facilities visited included:

- Bellwood Health Services Inc., Scarborough;
- The Donwood Institute, Toronto;
- Pedahbun Lodge, Toronto;
- The Jean Tweed Treatment Centre, Toronto, and
- The Renascent Centres, Downsview.

The Committee had several objectives in visiting these clinics. The Members wanted to experience the daily operations of the centres; to provide a forum for the employees to express their concerns; to compare in general terms, the Ontario and the U.S. clinics, and to make recommendations to assist the Ontario treatment system in adapting to future demands. The meetings with these centres permitted the Members to discuss a broad range of topics, for example:

- profile of Ontario patients,
- the assessment and referral system,
- the availability of treatment,
- treatment programs,
- special service needs,
- follow-up and after care of patients,
- the accreditation of professionals,
- costs and funding, etc.

The following summary indicates that the profile of Ontario patients and the system have changed in recent years. The treatment system has been described as proactive and innovative in responding to evolving patients' needs through new programs. The visits are summarized in the Committee's observations, as follows:

Patients' Profile

- Patients are representative of all segments of the community. It is not a homogeneous group with a single dependency.
- Special programs are needed for women, the elderly, adolescents and aboriginal groups, for example.
- Poly-drug usage is becoming more prevalent and there are more dual diagnosis cases, that is people with both addictions and psychiatric problems. Cross addictions have contributed to costs and program difficulties in providing treatment.

Assessment and Referral

- The treatment facilities stress the importance of the initial assessment stage to identify the problem(s) in precise terms (e.g. dual disorders, cross addictions, sexual abuse, etc.), and the appropriate treatment.
- The waiting period for an assessment appointment can be ten days to two weeks.
- Metropolitan Toronto has a shortage of assessment and referral services. Some are of the view that treatment facilities should be expanded prior to the introduction of more assessment and referral centres.
- Referrals for assessment are made through many sources, such as family, friends, unions, corporations, social and community agencies, etc.

Availability of Treatment

- In some instances patients want immediate access to a residential treatment program, through an employer referral for example, and they can not be accommodated. Patients have been referred to U.S. facilities because of

the availability of immediate treatment and/or special programs (e.g. adolescent programs).

- Patients' needs are not being met in all regions of the province as demonstrated by out-of-country referrals. Regional centres have been discussed as one treatment option to assist in pooling resources on a decentralized basis.

- If patients cannot be treated in a timely manner, they may decide to not pursue treatment.

- The view was expressed that Metropolitan Toronto is in need of short-term ambulatory programs, after care and in some cases residential programs.

- Treatment on an in-custody basis is limited.

Treatment Programs

- There is support to move gradually from the traditional residential treatment model to community-based ambulatory programs. This approach is seen to be less expensive, with potential for long-term success. Certain facilities stress the out-patient option as it is cost-effective and it can be complementary to a patient's daily commitments, for example, child care.

- Some patients insist on residential treatment when an outpatient treatment program would be appropriate. All patients do not require a residential treatment program and would be better suited to outpatient treatment in close proximity to their family, relying on community services and local professionals.

- Ontario treatment facilities offer a range of programs, but in some instances waiting lists are a problem. Also, services are not available in all regions of the province.

- Treatment often incorporates a multi-disciplinary approach, using case management or case conference methods. The treatment models may include Alcoholics Anonymous, a medical model, etc.

- Some programs are broad in scope, incorporating the nutritional and exercise aspects of therapy, similar to some U.S. programs. Programs to address sexual and/or emotional abuse, weight problems and eating disorders, dual disorders, specialized programs for women, natives and adolescents, for example, are necessary. In some clinics these programs are being developed and in others, capacity and/or resources may be limited.

- The evaluation of treatment "success" varies. It may be based on several factors, such as social skills, coping strategies, as well as total abstinence and the number of minor relapses.

- There is a public perception that treatment must be hospital-based for a specified treatment period. The need for a public education program to explain the benefits of other treatment options was emphasized.

Special Services

- There is a need for services for certain sectors of the community, such as: adolescents, natives, women and cultural minorities (programs sensitive to cultural and linguistic groups). Some clinics in Ontario do offer programs for special groups, but a gap in services is evident in certain regions.

- Female patients present unique treatment challenges in addition to substance abuse, for example, sexual abuse issues and eating disorders. Also, the absence of support services such as child care may provide a barrier to treatment. Programs are being considered and developed to address these special treatment needs and related problems, such as the prevention of foetal alcohol syndrome.

- Native peoples require special programs that are respectful of their culture, traditions and historical background. Treatment programs are not always sensitive to traditional healing methods. Furthermore, programs are not coordinated in all cases among treatment centres.

Follow-up and After Care

- The treatment models stress the importance of follow-up, after care and the role of support groups. The methods used may include contact through an 800 phone number; "networking" with community professionals; program mailings; relapse prevention programs, etc. After care and support groups are not available in all areas, particularly remote parts of the province.

- After care programs could include follow-up over a two year period, a volunteer program, reunions, assertiveness/renewal programs, and special groups such as Women for Sobriety.

- AA (e.g. Alanon, Alateen, etc.) is often incorporated in after care programs in conjunction with a support group.

- Some treatment facilities in Ontario provide after care services for patients treated in the U.S.

Accreditation

- The treatment centres have accreditation requirements which, depending on the type of facility, may be inspected by the Ministry of Health and the Canadian Council on Health Facilities Accreditation, for example. Professionals may obtain accreditation through the Addictions Intervention Association (AIA).

Financial Considerations

- The U.S. treatment programs are more expensive generally than comparable Ontario facilities.

- In some instances people employed in the substance abuse treatment system in Ontario feel that their salaries are not competitive.

- Some professionals feel that current funding levels prohibit effective service delivery in such areas as day care, after care, specialization in treatment programs for natives and women, for example.

Visits to U.S. Facilities

The Committee visited the following substance abuse clinics in the United States during the period August 12-16, 1991:

- Hazelden Rehabilitation Centre, Centre City, Minnesota;

- Fairview Deaconness/Riverside Medical Centre, Minneapolis, Minnesota;

- Parkside Lutheran Hospital, Park Ridge, Illinois;

- Beech Hill Hospital, Dublin, New Hampshire; and,

- Spofford Hall, Spofford, New Hampshire.

The Committee made the following observations during the visit to the U.S. clinics:

- The clinics may offer a medical or non medical treatment program with or without Alcoholics Anonymous (12-step program: Alanon, Alateen and Alatot, etc.) in the after care stage.

- The needs of special groups such as native peoples, the deaf community, adolescents, etc., are addressed in some facilities through separate programs.

- Many of the centres have a number of recovering alcoholics on staff and training programs for counsellors.

- The importance of the initial patient assessment by multi-disciplinary staff was emphasized.

- The treatment of patients was described as multi-disciplinary, using a team approach.

- The holistic approach to treatment is often used, stressing the diverse needs of the patient, such as exercise programs, diet, family relations, etc.

- Some centres could treat complex problems such as dual disorders, etc.

- The types of problems being treated have evolved from alcohol-related issues to poly-drug problems involving cocaine for example, which present new challenges in cross-addictions treatment.

- Some of the facilities offer follow-up programs for Canadian patients with after care arrangements in Ontario. After care and the initial assessment are seen to be of critical importance in the treatment cycle.

- Certain facilities have prepared profiles on Canadian patients. The view was expressed that in some instances, the U.S. clinics are receiving the most severe Canadian cases and that these patients are in need of residential treatment programs in the majority of cases.

Following the visit to the U.S. facilities, the Committee identified several areas in need of further investigation in the Ontario system; namely, substance abuse treatment in the correctional system; out-patient versus in-patient treatment options; cost effectiveness; congruence in Ontario between programs and patient needs; accreditation and training for professionals; special programs for adolescents, women, multicultural and native groups; after care programs; and educational and preventative programs.

Some Members concluded that aspects of the treatment facilities in the U.S. are progressive, particularly the programs for special groups, such as adolescents, but the issue of the cost of treatment was a major concern. The Committee agreed

that U.S. clinics should be used on a limited basis to complement the provincial system in the area of special programs and when urgent cases can not be admitted for treatment in Ontario, following prior approval.

Overview of the U.S. and Ontario Visits

The Committee reached several general conclusions based on its visits to Ontario and U.S. treatment facilities.

- the Ontario programs are of a high standard, although the U.S. has developed areas of expertise in certain programs, which are not always readily available in Ontario, for example treatment for adolescents and native peoples;

- in some instances U.S. programs are more accessible than Ontario facilities, without the problem of waiting periods;

- the U.S. facilities are expensive compared to treatment in Ontario. U.S. clinics have promoted services in Ontario through local offices/representatives;

- Ontario and U.S. facilities offer various medical and non-medical treatment options, and

- after care is recognized as an essential component in the U.S. and Ontario systems, although problems may develop for patients returning to regions with minimal community services and support programs.

AN ASSESSMENT OF THE ONTARIO TREATMENT SYSTEM

During the hearings, the witnesses explained both strengths and shortcomings in the present treatment system in Ontario. The topics in need of attention are primarily in the areas of administration and program requirements, rather than the quality of treatment.

The following comments, by various witnesses, indicate that treatment is effective, but that improvements are needed throughout the system. The Ministry of Health officials made the following observations:

- . . . for some services there are waiting lists, . . .

- . . . for certain people with specific problems there are some services that are unavailable or where there is a wait that would be found to be a problem.

- . . . for people with dual disorders, who have a psychiatric and an addiction problem, there is a need to get them into a comprehensive treatment program, and the resources are a bit strained here.

- Similarly for some of the youth, the Provincial Anti-Drug Secretariat identified in its report that there really was a need to expand youth programs.

- . . . most people do not require residential treatment. The research evidence is overwhelming that outpatient treatment can be as cost effective.

- . . . the issue of immediacy is not critical. You do not necessarily need treatment tomorrow. What you may need is detoxification tomorrow and support, and that is certainly the direction in which we [Ministry] are trying to move the system.

The need for improvements to the treatment system in Ontario is generally recognized. The Ministry of Health explained its current priorities:

> . . . we continue to emphasize very strongly the importance of community-based programs, non-institutional-based programs, which are the most effective for the vast majority of substance abusers and the ones most likely to last the longest time; that is, keep people off drugs the longest time.
>
> We recognize that for a small number -- and our assessments by outside experts confirm that it is indeed for a very small number -- there is a need for a period of institutional treatment. . . . Under those circumstances, but only under those circumstances, are we in a position to say that the

> United States has something that we do not as yet have a capacity for in Ontario.
>
> Comparing facility for facility, when a facility is indicated, and I emphasize that point, our best advice at the moment, and subject to any further findings from the committee, is that our facilities are as good as anywhere . . . . I repeat, only because it bears repeating, that institutional treatment is not always necessary and is certainly not the most cost-effective treatment when it is not necessary.

It is generally accepted that Ontario is in need of expanded treatment services, however, the misconception that people have to have residential care to be in an effective program has to be addressed, according to the witnesses. Many people can be treated on an outpatient basis, as established through assessment. It has been suggested that out-patient treatment is cost effective and appropriate for many patients.

The Addiction Research Foundation confirmed other witnesses' views on accessibility and the quality of Ontario programs, in comparison to those in the U.S.:

> . . . there is clearly no evidence that American treatment programs are more effective than Canadian programs. The principal reason for people going there is generally one of accessibility . . . There are other considerations as well in some instances, such as a particular preference for the type of program.

ARF stated that Ontario does not have adequate services and that the current capacity is in the order of a half to a third of the per capita capacity in other jurisdictions. The Foundation made several comments on the system requirements in Ontario.

> So one would want to see, in expanding the service system in Ontario, some emphasis be given to expanding in the area of making more outpatient

> services available, primarily because, with limited dollars available for such expansion, we can be helping a lot more people on an outpatient basis.
>
> In the short term, in terms of things that need to be done, we do need an expansion of services in the province.

Some of the reasons for the dependency on out-of-province treatment were noted by the Donwood, as follows:

> . . . one has to address the lack of the range of the resources necessary in Ontario; second, poor matching of people to programs; third, the marketing and recruiting practices of U.S. facilities; fourth, the increased role played by referral agents, sometimes termed "brokers."

In addition, the Donwood noted the lack of assessment and referral services in Metropolitan Toronto, the need for short-term ambulatory programs and the lack of capacity in after care. Also, specialized programs are necessary for specific segments of the populations; such as young people (adolescents and transitional youth), women and cultural minorities with a focus on linguistic needs. The need for community-based programs to treat residents in their communities was stressed. According to the Donwood Institute, Ontario based-treatment has several benefits:

> . . . It is less costly. There is good data to support that. There is a more complete recovery program, and that is primarily assessment and after care. It is closer to community and family and it can be ambulatory and, where appropriate, less intensive. It avoids . . . the social ostracism of sending people away. This is a stigmatic area and sending people away only reinforces that stigma.

The Committee has recognized that the major challenge is to determine long-term treatment needs and system requirements. ARF confirmed the need for clarification of program needs across the system, for example, in terms of residential versus outpatient options.

> We really do not know where the answer lies in terms of those kinds of things [residential treatment versus outpatient options], because there are not enough data available, details of the situation to really fine-tune it so it can come down to a question of where to start. One way of looking at that is to start by expanding the residential services and monitor the needs or start by expanding the out-patient services and monitor what happens with respect to the residential needs.

The lack of information to make sound decisions should be addressed. Decision-making must be based on accurate data to ensure that resources allocated are used effectively to address long-term treatment needs. The witnesses have indicated that the Ontario system offers quality treatment at the present time, but that there are problems that must be addressed, such as: the waiting list/capacity problem, the lack of programs for youths, and the need to redirect patients into non-institutional programs. In the development of a new and improved system it is important to emphasize the point made by ARF, that the U.S. system is not more effective than Ontario's, based on available evidence, and that in many cases patients have pursued treatment in U.S. clinics for reasons of accessibility.

TREATMENT SYSTEM REVIEW

The Committee is in agreement with the Ministry of Health that public funds should be used to provide treatment for substance abuse patients in Ontario, rather than out-of-province. In certain situations this will not be possible, and treatment alternatives will be required and permitted in other jurisdictions.

The Committee has concluded, based on its visits to ten clinics and the hearings, that the Ontario treatment system is attempting to provide the best services possible with the available resources. However, new treatment needs have placed increasing demands on the system. For example, the evolving nature of substance abuse problems now includes more female and adolescent patients and treatment requirements include complex dual diagnosis and poly-drug cases. The system is

further strained through the need for improved after care and child care facilities. The rapidity of change has made it difficult to adapt with new services and facilities throughout the province.

The Committee recognizes the importance of the studies that have been prepared on the substance abuse treatment system in Ontario. The provincial Ministries of Health, Community and Social Services, and Correctional Services, as well as organizations such as the Addiction Research Foundation, address the challenges of treatment on a daily basis. Most recently, the final report of the Advisory Committee on Drug Treatment, entitled "Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's" and the report of the Task Group, Public Consultation on the Advisory Committee Report on Drug Treatment, "Caring For Each Other" have been the subject of review.

The Committee views the system-wide concerns addressed in these reports as separate and distinct from the focus of the current consultation paper entitled "Redirection of Long-Term Care and Support Services in Ontario" sponsored by the Ministries of Community and Social Services, Health and Citizenship. However, the consultation paper may benefit the substance abuse treatment system through various innovations, for example in the study of community-based services.

The Committee has concluded that "Vision for the 90's" was an important step in the review of the existing system. The treatment principles defined in this report represent a new management focus for a complex service delivery system. The principles address specific treatment issues, such as, accessibility to treatment facilities, continuity of care, early intervention, the definition of treatment benefits, multiple treatment options, comprehensive assessment and addiction-specific options. Although service delivery is the primary objective in the treatment system, the management must be improved. Some fundamental questions must be asked, for example . . . "What kind of treatment system is needed to provide services for substance abuse patients, in an effective and

efficient way in the future?" and . . . "How should the system be structured and managed?"

These principles emphasize the need for centralized management with a balanced and coordinated system of program and service delivery. The emphasis on local planning and cost effectiveness; the expansion of service functions; program evaluation and quality assurance procedures, and the coordination for the maximization of effectiveness and efficiency should be addressed in a restructured system, according to a "Vision for the 90's".

The Advisory Committee outlined structural/management concerns in the guiding principles, for example:

> Alcohol and drug problems can be most comprehensively addressed by a balanced system of addictions-specific services and programs for alcohol and drug problems located within the more generic health, social, and correctional service systems.
>
> Introducing services for drug and alcohol problems into a broader range of service system requires: 1) administrative commitment, 2) funding, 3) mandate, and 4) training.
>
> The distinction between "community-based" and "hospital-based" services should be replaced by one which places more explicit emphasis on local planning and cost-effectiveness.

The Advisory Committee addressed management problems within the current system, for example, the need to improve coordination at the client, agency and funding levels. As discussed in the "Vision for the 90's", certain program needs in the Ontario treatment system must be addressed, for example, ". . . the province is currently under serviced"; and there are requirements for ". . .more outpatient treatment services"; ". . . short-term residential programs for youth" (e.g., adolescents); ". . . early identification and intervention programs . . ."; ". . . expanding the capacity of some assessment and referral centres; more

services, such as case management to improve continuity of care; additional non-medical detoxification capacity", etc.

A new system for the treatment of substance abuse patients must address program delivery. "A Vision for the 90's" addressed several systemic problems in service delivery, for example:

> The appropriate balance between the treatment of drug and alcohol problems in the addictions-specific and other service systems will be influenced by population characteristics.
>
> The comprehensive range of service functions envisioned includes information and referral, outreach, early intervention and crisis functions in addition to those usually considered to comprise the continuum of care.
>
> Program evaluation and quality assurance procedures are critical features of a comprehensive and effective treatment system.
>
> Coordination makes an important contribution to the maximization of effectiveness and efficiency in a complex service delivery system.

During the first weeks of operation, problems were identified in the treatment system. ARF explained the complexity of the Drug/Alcohol Registry of Treatment (DART) program from a management perspective. The organization of the treatment system has presented certain challenges which would have to be addressed:

> It was an extremely complex project. . . . there are about 200 of these [treatment related] programs and they offer very varied services. They are funded by different ministries.

The Task Group that reported on "Vision For The 90's" explained to the Committee that several steps had been taken to address problems within the treatment system. For example, the Ministry of Health has introduced

restructuring through a "reform agenda". The Anti-Drug Secretariat has been transferred to the Community Health Division and the majority of treatment programs are funded by the Mental Health Branch. Also, the coordination of issues on addictions policy and programs, administered by several ministries, are being reviewed. Finally, a report is being prepared by ARF to address treatment coordination. The report expected in 1993, will include an "extensive evaluation of 23 treatment programs funded by three ministries."

Strategic Plan Review

The Committee concluded that a working group is required to assist in the development of a long-term strategic plan for the Ontario substance abuse treatment system. A broad mandate is necessary to permit this group to study all matters relevant to substance abuse treatment in the province and to recommend changes to address administrative and service delivery needs over the long-term.

The working group may consider, but should not be limited to the following:

> the establishment of a central authority to ensure overall coordination of funding and service delivery;
>
> the adoption of a new policy framework for the delivery of treatment services in Ontario;
>
> an assessment of program needs and the availability of resources, based on multi-year projections;
>
> the definition of an implementation program for a new treatment system, indicating the recommended strategy and alternate phasing options;
>
> an ongoing system review mechanism to address: treatment requirements; standards and economy, and efficiency and effectiveness in service delivery.

The appropriate design and management of a treatment system are important to realizing the long-term goals and objectives in programs and services . For example, inefficiencies in the current system such as the lack of coordination

among programs and ministries must be resolved. The working group should assess management's capacity to coordinate the delivery of programs and services at the client, agency and funding levels. Also, any adjustments to the treatment system should account for multi-year funding requirements.

In summary, an operational review of all ministries and bodies involved in the delivery of services for the treatment of substance abuse in Ontario is required. The review should develop a rationalized system to ensure efficiency, effectiveness and economy in the delivery of treatment services. A working group should address program/service delivery needs and management requirements; develop principles on long-term treatment goals and objectives; define a strategic plan(s) for implementation stages with a multi-year program, and assess treatment services coordination and delivery. The strategic plan should address the findings of the reports entitled "Vision for the 90's" and "Caring For Each Other".

The Committee therefore recommends that:

1. ***A working group should be established to study all aspects of the substance abuse treatment system in Ontario. This body's mandate could include the development of principles and long-term goals and objectives for an improved treatment system. The study could include an assessment of the strengths and weaknesses of the current system; the definition of a strategic plan(s) for change, and an outline of the proposed stages to implement such a system. The implementation process could be outlined in defined stages which could be introduced gradually, if necessary, taking into account such factors as the availability of resources.***

The membership of the working group should have broad representation including government, former substance abuse patients, professionals in the health care field, as well as representatives from various segments of the community, including special interests, unions, business, etc. The review process could include, but should not be limited to public consultation, special studies, discussion forums, research papers and advisory groups.

The implementation strategy could include phasing alternatives and multi-year cost implications for a restructured system. The phasing component is important because it would permit the government to implement the project in manageable stages thereby enhancing the prospects of realizing the plan over the long-term. The "manageability" of the strategic plan is critical to its acceptance and implementation.

TREATMENT SYSTEM ISSUES

The Committee recognizes the ongoing efforts of governments, research organizations, practitioners and various groups to improve the treatment system in Ontario. The Committee has not commented on the technical aspects of service and program issues under review by various groups. However, the Committee has prepared recommendations on selected issues, related to the matters discussed in the Auditor's report, which should be considered in a system-wide study.

The availability of programs and capacity or spaces for treatment of patients in Ontario has been at the centre of the discussion on out-of-country OHIP payments. In the past, patients have preferred to pursue treatment in the U.S. if residential spaces were not available in Ontario clinics. The DART director commented on the length of waiting periods in Ontario, as follows:

> I do not see any information that we have now in the first three weeks [of operation] that would say there is enough treatment here [Ontario]. The waiting period, on average, for the residential programs, is a month or longer. In some of the best programs, the most highly respected programs, it is six months.
>
> We are definitely weak in terms of outpatient and non-residential programs, and I believe we are definitely weak in terms of residential programs for young people.

The Auditor's report on out-of-province OHIP payments raised issues that developed, in part, through capacity problems in the Ontario system. This section

addresses several topics which should be addressed in a review, namely: a profile of U.S. referrals; the new Drug/Alcohol Registry of Treatment; program requirements; the accreditation system; treatment in the correctional system; services for "special peoples"; after care programs, and AIDS and HIV infection considerations.

Profile of U.S. Referrals

The Ministry stressed the importance of a statistical base upon which to make decisions for improving the treatment system. For example, the research being conducted by the Ontario Mental Health Foundation, as a follow-up to the Ontario Health Survey (1990), may provide information on the prevalence of alcoholism and drug abuse. Research on the duration of substance abuse usage, treatment programs, patients' profile, and regional patterns could be helpful in the restructuring of the treatment system.

A statistical profile of Ontario referrals in recent years could help to define program needs. ARF explained that the data on Ontario patients treated in the U.S. is not available, although some clinics in the U.S. indicated that they have compiled this information on their Canadian patients:

> . . . the distribution of clients who go to these programs [U.S.] seems roughly similar to the people who use programs in Canada. So it is not clear that there is any one particular type of client who is most likely to be going to U.S. treatment programs. Distribution by age, at least, is very similar. There are no complete data available to us in order to be able to look in more detail at the types of clients who are going there.

ARF indicated that in some instances there have been preferences for particular programs in the U.S. However, it was pointed out that to simply replicate U.S. programs is not the answer, as the need for residential programs for example, is not proven.

The Committee has concluded that a profile of Ontario patients treated in U.S. clinics in recent years, in conjunction with statistics from the DART registry, would be helpful in defining program needs.

The Committee therefore recommends that:

2. *The Ministry of Health should prepare statistical information on Ontario patients treated in U.S. substance abuse clinics over the past 5 years. This profile on patient treatment out-of-province should be considered by the Ministry of Health in the identification of future treatment system requirements in Ontario.*

Drug and Alcohol Registry and Program Requirements

The Addiction Research Foundation is administering the DART program in Ontario. The DART program is of interest to the Committee because it was established in response to the need to ensure that a reasonable effort is made to obtain treatment facilities in Ontario, prior to considering treatment in other jurisdictions. ARF described the Ministry of Health's DART program as follows:

> The registry . . . was part of a three-pronged strategy that we saw develop within the Ministry of Health for dealing with the problem [out-of-province OHIP payments]. One was that OHIP would tighten the rules and regulations, and it has already done some of that . . .
>
> Second, other parts of the ministry, the community mental health branch in particular, were asked to increase funding and expand services in the province. So at the same time we reduce access to the States, we provide more services in Ontario.
>
> Third, the Addiction Research Foundation was asked to develop the registry, which would provide a way on any given day of documenting what space was available in the province and also help direct people to that space, again to make the best use of our own resources . . .

The DART program has several objectives according to ARF: to list available facilities, to indicate waiting periods and to prepare a routine update (a statistical report on availability). A patient is required to visit an assessment centre and to contact the Registry. The Registry ensures a reasonable search in Ontario for treatment, prior to approval for out-of-country treatment, according to ARF. The objective is to use the Registry's information base to improve the allocation of patients within the Ontario treatment system.

The matching of service needs with treatment capacity, in the Ontario system is essential to ensuring value-for-money. As fewer patients will be treated in the U.S., improvements will be required to upgrade and expand Ontario programs to meet demand.

The Committee therefore recommends that:

3. ***The Addiction Research Foundation should prepare a report on treatment requirements in Ontario facilities based on the first year of the DART program. This report should include a profile (1991-1992) of Ontario patients' requirements, the system's capacity (1992) and projected requirements for the purposes of preparing long-term plans (1992-2000).***

The lack of use of outpatient services has presented problems. According to the project director, the new data compiled by the Drug/Alcohol Registry of Treatment (DART) indicates that there is a reluctance to use these services. Also, DART has demonstrated that there is " . . . very little space in residential programs. . . . " The project director explained as follows:

> One thing we have seen in the registry data already is a reluctance to use outpatient programs . . . There continues to be a bias or a perspective that to get alcohol and drug treatment you have to go away somewhere. That applies for some people, but not for everyone.

The Committee is concerned that available outpatient programs are not being used to capacity when there has been a shortage of space in residential programs. A

patient's preference may be based on impressions of treatment which may not be substantiated in clinical experience. The value of educational material explaining the benefits of outpatient treatment was stressed during the hearings.

The Committee therefore recommends that:

4. ***The Ministry of Health should assess the DART data to determine the treatment requirements/capacity in relation to the actual use of outpatient and residential treatment programs. The Ministry should take the necessary steps through the use of educational materials, to address any bias against outpatient programs.***

Accreditation

The accreditation of professionals in the treatment system was discussed by the Committee in relation to the DART program. The Committee addressed whether there are enough trained professionals to provide the required services for Ontario patients and who should be registered as an "accredited" professional in the field.

The Community Mental Health Branch, Ministry of Health explained the present accreditation system in Ontario for professionals in addiction treatment, as follows:

> . . . the only body in Ontario and Canada responsible for this [accreditation] is the Addictions Intervention Association (AIA). This non-profit body is responsible for the certification of addiction counsellors and awards the Certificates in Alcohol and Drug Counselling (CADC). This certification has been in place for only one year and replaces the previous Certificate in Alcohol Counselling (CAC).
>
> It is estimated that approximately 75% of addiction counselling staff in programs funded through the Community Mental Health Branch have, at minimum, CAC certification. Many of these individuals come to addiction programs from other professional streams, including social work, nursing, psychology and occupational therapy.

According to the AIA, their role is to certify practitioners. At the present time a licence is not required to practice as an addiction counsellor in Ontario. Also, the DART project director explained that there is not a regulatory requirement establishing standards for substance abuse counsellors in Ontario. The director expressed the following concerns on accreditation, in relation to DART's mandate:

> I think this [accreditation] is something that should be addressed in the system. It really is around the whole issue of quality assurance. It is broader than just the credentials of the staff; it is what kinds of treatment should be offered and how many staff people should be available for any given individual.
>
> In many types of facilities these things are all worked out. I do not think we have that in Ontario. Part of the reason is that historically they have been funded through so many different branches of government -- the Ministry of Correctional Services, the Ministry of Housing, the Ministry of Health, the Ministry of Community and Social Services -- the United Way and so on. Historically it has been a very fragmented system. A lot of the changes that are coming try to make it a more centralized, systematic kind of planning. With that, I think we need some attention to the credentialling.

The Registry must decide who should be listed in an effort to provide quality assurance in the system. The Committee is of the opinion that training programs through ARF, community colleges and other institutions need to be standardized for purposes of accreditation of practitioners.

Regulatory requirements are in force in many areas of the health care system. Ontario treatment facilities must comply with standards set by the Ministry of Health under a hospital license, for example. The Ministry of Health conducts inspections and other accreditation bodies such as the Canadian Council of Health Facilities Accreditation (CCHFA) offer accreditation.

To assist the DART program, the Committee has concluded that clarification should be made by the Ministry of Health on who should be included in the

Registry. Standards should be established to regulate substance abuse counsellors in Ontario.

The Committee therefore recommends that:

5. ***The proposed working group, in conjunction with the Ministry of Health, should move to develop uniform standards for people practising in the field of substance abuse treatment and treatment facilities in Ontario, in consultation with the Addictions Intervention Association. The standardization of credentials could incorporate the accreditation offered through the Addictions Intervention Association. An accreditation system should be addressed in developing Registry standards for the DART system which would help to promote quality assurance.***

Treatment on an In-Custody Basis

The Committee addressed the availability of treatment on an "in-custody basis", within the provincial corrections system. Inmates with a substance abuse problem should receive treatment to reduce recidivism or the "revolving-door" problem in the correctional system.

The 1990 Annual Report of the Ministry of Correctional Services documented the Ministry's initiatives on treatment and rehabilitation programs for offenders. The problems of alcoholism and substance abuse are addressed through various programs with the assistance of psychologists, social workers and other professionals offering individual, family and group counselling, case coordination, assessments, crisis intervention, discharge planning and community liaison. The Ministry's institutions and probation offices offer treatment and rehabilitative programs for adult and young offenders. The Ministry feels that it is improving services for all groups.

Youth services are provided at probation offices, youth centres and open custody residential locations. Young people with "a disposition to secure custody" receive an initial assessment for the purpose of developing "an individualized plan of care which prescribes the recommended treatment plan." Young people in the

community have rehabilitative program options through probation, parole offices and contracted open custody residences, according to the Ministry's Annual Report.

The proposed regional centres, as explained in the Annual Report, will offer new services for substance abuse offenders, as follows:

> Regional treatment centres will provide support services for community treatment programs and clinical intervention for those offenders who evidence drug or alcohol addictions, are emotionally disturbed, have short sentences (less than six months) and do not require specialized, intensive treatment or handling.

The Ministry of Correctional Services with community groups, provides community treatment options in areas such as life skills.

The Committee pursued the issue of the availability of treatment on an in-custody basis for people within the provincial correctional system. The Members expressed the view that all people in the correctional system with alcohol and/or drug problems should receive substance abuse treatment. The combined problems of substance abuse and crime have resulted in a "revolving door syndrome" of repeat offenses due in part to a lack of proper treatment.

The Ministry of Correctional Services explained to the Committee that the current treatment programs in the correctional system are multi-faceted, relying on a number of treatment facilities. They include programs for alcohol and drug awareness. The Ministry has assessment and treatment units, and programs with an emphasis on the abuse of alcohol and drugs. Some programs are operated on a shared basis with Correctional Service Canada. Furthermore, the treatment of substance abuse is a component of probation and parole programs.

The Ministry of Correctional Services officials summarized aspects of its treatment for substance abuse, as follows:

> In addition to those actual treatment centres and units . . . , in all of our institutions we have alcohol and drug problems that may range from AA coming in to an actual multidisciplinary approach, as I have mentioned. In our probation and parole areas, driving while impaired, we have 11 programs at the cost of $225,600 and we have substance abuse programs. We have 25 of those at a cost of $758,000. With our young offenders, we really do use a multidisciplinary program, caring approach because we recognize it is more than just alcohol and drugs. There are often educational programs and behavioral problems involved. It really is the whole child that is looked at.
>
> The young offender is involved in planning the care program for him, as well as a parent or guardian, if such is available to assist.

The Ministry has increased its involvement in these services and it has the capacity to move into the community to assist at the probation and parole stages. Recidivism rates could be a problem because treatment cannot be forced, according to the Ministry. However, in some jurisdictions inmates with drug related crimes are required to take treatment through parole decisions.

ARF commented on the availability of programs in the correctional system and the need to address the linkage between crime and substance abuse:

> There are some programs in the correctional system and there are certainly individuals who are part of the correctional system who are making use of the public treatment system. Certainly from the perspective of the advisory committee we felt this was an area that needed a good deal of attention. We know, for example, estimates are that as high as 75% to 80% of individuals in correctional settings are there for reasons related to alcohol and drug problems. I think a lot more needs to be done in that area because there is clearly a strong association between the two problems.

The DART project director commented on the adequacy of treatment within the correctional system:

> There are a small number of programs which operate in some correctional institutions like the Rideau Correctional Centre in the east, for example. There are some programs operated in community resource centres, I believe they are called, and there are others like Portage Ontario, which is a treatment centre for young offenders. So there is a range of programs. My opinion is there are not enough.
>
> . . . I think there are too many restrictions placed within many of the programs. They will not take the client if there are legal charges pending or if they are on probation or what have you.

Portage Ontario representatives met with the Committee to discuss their program which offers a therapeutic community for young offenders in a residential open-custody facility. On the topic of the availability of treatment, Portage Ontario offered the following comments:

> We think there should be more programs like ours in Ontario for adults as well as adolescents. We would very much like to be able to provide beds for adolescents who are not offenders as well as the few who in fact are young offenders and are appropriate for our program.

ARF has been involved with research in the area of relapse-prevention strategies, for example, to develop programming models for correctional facilities. Treatment facilities have dealt with referrals from probation, some of whom have been admitted to after care programs. The Donwood expressed the view that this part of the treatment equation has been neglected. Treatment facilities, such as the Donwood, provide treatment to people with criminal records.

The Advisory Committee on Drug Treatment considered this subject and recommended that "all offenders in the provincial correctional system with alcohol and drug problems have access to appropriate assessment and treatment programs". The Standing Committee on Public Accounts concurs with this statement and has included the Advisory Committee's supplementary comments to this recommendation to indicate the scope of treatment needs in the correctional

system, according to the Advisory Committee. The Advisory Committee recommended as follows (Recommendation VII, "A Vision for The 90's"):

i) that the Ministry of Correctional Services establish alcohol and drug treatment programs in Community Resource Centres (C.R.C.) as one community option for low-risk offenders;

ii) that the Ministry of Correctional Services expand alcohol and drug assessment and treatment programs within its treatment institutions for offenders who are not yet suitable for a community option.

iii) that the Ministry of Correctional Services fund training and staffing to ensure that continuing care and case management functions are provided within probation and parole services;

iv) that the Ministries of Health and Correctional Services collaborate to identify mechanisms by which incarcerated individuals, offenders under probation or parole, and ex-offenders could make more extensive use of community assessment and treatment programs;

v) that community treatment programs review their admission criteria and make any necessary revisions to ensure that ex-offenders and current offenders in community options have equitable access to treatment programs;

vi) that the Ministry of Correctional Services fund training programs to ensure that these new or expanded treatment services are effectively delivered.

The Committee is of the opinion that effective treatment options for those in the correctional system are essential to reducing the incidence of drug-related crimes and repeat offenses.

The Committee therefore recommends that:

6. ***A comprehensive review and assessment of substance abuse treatment facilities should be conducted for inmates in the provincial correctional system. All inmates should be eligible for treatment programs. Programs in the community should be required to treat inmates, and those on probation or with legal charges pending.***

Special Treatment Programs

The Advisory Committee on Drug Treatment addressed the treatment concerns of various groups collectively referred to as "special populations". These include native people, youths, the elderly, patients with dual disorders, women, francophones, ethno-cultural groups and the "homeless". The Committee has had the opportunity to discuss the needs of these peoples and the treatment programs in general terms.

The Committee decided during this investigation not to make recommendations to address the treatment needs of each of these groups. Experts in the field may be required to review the various program and service requirements in conjunction with the proposed working group.

The Committee had the opportunity to discuss the needs of adolescents and women, for example, which apply across the system. The Members have offered comments on these groups, as an initial step in encouraging recognition of the scope and complexity of the problems affecting "special populations".

Services for Youths

The Ministry of Health acknowledged the need for the expansion of youth treatment programs in Ontario and appropriate case management support. For example, the Ministry is developing a program to provide housing and life skills for young people. The Donwood identified major shortcomings in available

treatment for young people, which is compounded by a lack of resources and in some instances the distance between one's residence and the programs.

According to the DART project director, there are outpatient programs for the under 16 population being developed through the Ministries of Community and Social Services and Health. The project director noted that there is concern about young people being placed in residential programs, separate from their home environment for a 28 day program. The DART program has confirmed the weakness in residential programs for young people.

Portage Ontario representatives discussed the issue of the availability of treatment for youths. The lack of facilities for youths was confirmed, particularly for those under 14 years of age.

Services for Women

Special treatment programs for women have been developed, however the lack of certain program requirements, such as child care, have prevented patients from taking treatment. Some facilities offer treatment for abuse cases and address foetal alcohol syndrome, for example. The Task Group identified the unique nature of treatment problems confronting women. Specialized programs are needed to treat patients with substance abuse problems compounded by sexual abuse, domestic violence, marital breakdown, and poverty, for example.

After Care Programs

The Ministry of Health emphasized the role of after care as an integral part of the recovery cycle. The Ministry explained that ". . . where there is strong and ongoing and continuous community-based linkage, the rate of recidivism is much lower than where there is short-term residential intervention without that community component." In most cases a patient cannot be cured in a four to six

week residential program, according to the Ministry. There is the need for a continuing support program over the long-term, particularly for severe cases.

Some treatment programs in the U.S. lack adequate continuing therapy for patients returning to Ontario. Others provide follow-up programs which may involve provincial agencies.

AIDS and HIV Infection

The Advisory Committee on Drug Treatment prepared three recommendations on HIV/AIDS prevention. It supported a multi-faceted HIV prevention program, that substance abuse programs designate a staff member as "HIV Coordinator, and that treatment programs provide equitable access to HIV positive patients.

The Committee addressed a related issue of whether a person in contact with a person carrying a communicable disease has the right to be informed. Some Members are of the opinion that the Freedom of Information and Protection of Privacy Act should be amended to permit the notification of people in possible danger, while maintaining an individual's privacy. Presumably once an individual is informed of contact with a communicable disease they are able to take the necessary preventative steps to address the problem. The Committee does not believe that infected individuals should be identified, but that people providing care, such as firefighters and ambulance drivers for example, should be protected.

The Standing Committee on the Legislative Assembly tabled a report entitled "Review of the Freedom of Information and Protection of Privacy Act, 1987" in December 1991 which addresses that Committee's concerns and explains the current status of this issue. The Standing Committee on the Legislative Assembly commented on health care records, as follows:

> The Committee notes that the Ministry of Health is currently reviewing all health-related information issues for the purposes of the proposed *Health Care Information Access and Privacy Act*. It is the

> Committee's understanding that the issues raised before it concerning access to personal information related to health care will be dealt with under the Ministry of Health's proposed legislation.

The discussion of personal privacy and communicable diseases raised the issue of the protection of emergency services personnel. Amendments were proposed by the Standing Committee on the Legislative Assembly to the personal privacy provisions which would permit the notification of emergency services personnel in contact with someone with a communicable disease. It was suggested that the infected person's name would be protected. The Standing Committee on the Legislative Assembly reached the following conclusions on this issue:

> The Committee notes that, under subsection 42(h) of the Act, an institution is permitted to disclose personal information "in compelling circumstances affecting the health or safety of an individual". Thus, the concerns raised by the emergency services personnel groups are, in a general way, already addressed by the Act. If specific provisions governing this issue are deemed necessary, it is the Committee's view that it would be more appropriate for such provisions to be included in other legislation, such as the *Health Protection and Promotion Act, 1983* or the Ministry of Health's proposed *Health Care Information Access and Privacy Act*.

CONCLUSION

The Committee's decision to investigate the audit report on out-of-province OHIP payments was based on the concern with the out-flow of provincial funds and patients to treatment facilities in the U.S., the capacity of the Ontario treatment system and the need for improvements in programs and services generally. During the investigation, the Ministry of Health introduced policies which have addressed many of the Auditor's main concerns, however, certain problems still exist. The Committee has concluded that a strategic review of the substance abuse

treatment system, by a working group, is required to address the treatment challenges of the future.

LIST OF RECOMMENDATIONS

1. *A working group should be established to study all aspects of the substance abuse treatment system in Ontario. This body's mandate could include the development of principles and long-term goals and objectives for an improved treatment system. The study could include an assessment of the strengths and weaknesses of the current system; the definition of a strategic plan(s) for change, and an outline of the proposed stages to implement such a system. The implementation process could be outlined in defined stages which could be introduced gradually, if necessary, taking into account such factors as the availability of resources.*

2. *The Ministry of Health should prepare statistical information on Ontario patients treated in U.S. substance abuse clinics over the past 5 years. This profile on patient treatment out-of-province should be considered by the Ministry of Health in the identification of future treatment system requirements in Ontario.*

3. *The Addiction Research Foundation should prepare a report on treatment requirements in Ontario facilities based on the first year of the DART program. This report should include a profile (1991-1992) of Ontario patients' requirements, the system's capacity (1992) and projected requirements for the purposes of preparing long-term plans (1992-2000).*

4. *The Ministry of Health should assess the DART data to determine the treatment requirements/capacity in relation to the actual use of outpatient and residential treatment programs. The Ministry should take the necessary steps through the use of educational materials, to address any bias against outpatient programs.*

5. *The proposed working group, in conjunction with the Ministry of Health, should move to develop uniform standards for people practising in the field of substance abuse treatment and treatment facilities in Ontario, in consultation with the Addictions Intervention Association. The standardization of credentials could incorporate the accreditation offered through the Addictions Intervention Association. An accreditation system should be addressed in developing Registry standards for the DART system which would help to promote quality assurance.*

6. *A comprehensive review and assessment of substance abuse treatment facilities should be conducted for inmates in the provincial correctional system. All inmates should be eligible for treatment programs.*

Programs in the community should be required to treat inmates, and those on probation or with legal charges pending.

APPENDIX A

APPENDIX A

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Terms of Reference

The Standing Committee on Public Accounts is established pursuant to the Standing Order 104(j). Its permanent terms of reference, as set out in the Standing Orders, are as follows:

> 104(j) Standing Committee on Public Accounts which is empowered to review and report to the House its observations, opinions and recommendations on the Report of the Provincial Auditor and the Public Accounts, which documents shall be deemed to have been permanently referred to the Committee as they become available.

APPENDIX B

APPENDIX B

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Schedule of Hearings

Thursday, 6 June 1991

10.00 a.m. The Committee commenced consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

From the Ministry of Health:

Martin Barkin
Deputy Minister

Dave McNaughton
Assistant Deputy Minister

Bob McMillan
Executive Director

Steve Lurie
Co-ordinator
Mental Health and Addictions

From the Provincial Anti-Drug Secretariat

Jon Kelly
Director

Thursday, 13 June 1991

10.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

From Bellwood Health Services Inc.

Linda Bell
President

Frank Fuernkranz
Vice-President
Finance and Administration

From Addiction Research Foundation:

Garth Martin
Assistant Director
Research Dissemination Clinical Research & Treatment Institute

Thursday, 20 June 1991

10.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

From The Donwood Institute:

David Korn
President and Chief Executive Officer

Steven Sharpe
Vice-Chair of the Board of Directors

From the Ministry of Health:

Martin Barkin
Deputy Minister

Bob McMillan
Executive Director

Celia Denov
Executive Director

Cathy Fooks
Special Assistant, Policy

Steve Lurie
Co-ordinator Mental Health

From the Ministry of Correctional Services:

P.W. Humphries
Senior Medical Consultant and Manager
Clinical Services

Thursday, 27 June 1991

10.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

George Mammoliti, M.P.P.
Parliamentary Assistant to the Minister Responsible for Provincial Anti-Drug Strategy

From the Ministry Responsible for Provincial Anti-Drug Strategy:

Mary Shantz
Manager, Policy

From the Ministry of Health:

Martin Barkin
Deputy Minister

Dave McNaughton
Assistant Deputy Minister
Health Insurance and Systems

Tuesday, 13 August 1991

9.30 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Hazelden and Riverside Medical Centre, Minniapolis, Minnesota, U.S.A.

From Hazelden:

Harold Conlow
Vice President of Rehabilitation Services

Susan Engstrom
Information Specialist

Mike Early
Manager of Admissions/Assessment

Judy Gaetz
Director of Nursing

Sally Brandenburg
Licensing and Accreditations Specialist

Tom Orme
Counsellor Trainee

Gary Hestness
Manager of Community Relations

From Riverside Medical Centre:

Thomas M. Collins
Executive Director
Adolescent Chemical Dependency Services

Gregg Lorson

Tim Titus

Wednesday, 14 August 1991

1.00 p.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Parkside Lutheran Hospital, Chicago, Illinois, U.S.A.

From Parkside Lutheran Hospital:

Merill Kempfert
Executive Director

E. Delroy Stutzman, Jr., M.D.
Medical Director

Jim Costabilo
Marketing Director
Chicago Area (Community Relations)

Martin Doot, M.D.
Vice President
Medical Services, PMS

Kathy Martin, RN
Director of Nursing

William Filstead, Ph.D.
Vice President Research, PMS

Steve Ruohomaki
Director of Clinical Services

Lloyd Westover
Manager, Medical/Dual Diagnosis Unit

Deborah Costabilo
Manager
Eating Disorder

Jan Murphy
Manager
Polydrug Unit

Wayne Rhodes
Co-ordinator
Volunteer Programs

Thursday, 15 August 1991

3.30 p.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Spofford Hall, Spofford, New Hampshire, U.S.A.

From Spofford Hall:

William Hartigan
Senior Vice President Substance Abuse/Psychiatric Division

Tom Murphy
Executive Director

William Hawthorne, M.D.
Corporate Medical Director

Terry McClelland, M.A., C.A.C.
Clinical Director

Phyllis Johnson, R.N., M.S.
Quality Assurance/Utilization Review Director

Pierre Zimmerman, M.S.
Vice President
Northeast Regional Services

Friday, 16 August 1991

The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Beech Hill Hospital Inc., Dublin, New Hampshire, U.S.A.

From Beech Hill Hospital Inc.:

John McPeake, PhD, CAC
Senior Vice President of Clinical Programs

Barbara R. Duckett, RN, MS
Chief Executive Officer

James Potter, MD
Medical Director

Kathy Byrne, RN
Director of Nursing

Louise Sutherland, MA, CAS
Director of Therapeutic Services

Michael McNamee
Director of Beech Hill-Ottawa

Polly Burchard, NR, MBA
Director of Marketing

Thursday, 10 October 1991

9.30 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Bellwood Health Services Inc., Toronto, Ontario

From Bellwood Health Services Inc.:

Bill Livingston
Chairman of the Board

R. Gordon Bell
Honourary Chairman and Senior Consultant

M. Linda Bell
President and Chief Executive Officer

Frank Fuernkranz
Vice President of Finance and Administration

Janice Hambley
Vice President of Health and Clinical Services

Gerry Cooney
Medical Director

Gloria Gaudet
Senior Assessment Counsellor

Marg Flynn
Co-ordinator of Patient Care

Penny Lawson
Co-ordinator of Family Services

Toby Levinson
Co-ordinator of Continuing Health and Therapy Program

Thursday, 24 October 1991

10.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial

Auditor's 1990 Annual Report relating to the OHIP Billings

From the Addiction Research Foundation:

Brian Rush
Program Director
Drug and Alcohol Registry of Treatment

From Portage Ontario:

Michael Crowley
Director of Development

Parents of two "Young Offenders"

Thursday 31 October 1991

9.30 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Donwood Centre, Toronto, Ontario

From Donwood Centre:

David Korn
President and Chief Executive Officer

Richard Fralick
Director of Medical Services

Dennis James
Director of Program Operations

Joyce Gordon
Director of Community Services

Thursday, 21 November 1991

9.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited Pedahbun Lodge Incorporated, Toronto, Ontario

From Pedahbun Lodge Incorporated:

Clayton Mitchell
President
Board of Directors

Mike Davis
Secretary
Board of Directors

Gordon Loukes
Treasurer
Board of Directors

Bill Lee
Executive Member
Board of Directors

Ivy Chaske
Executive Director

Yvonne Lunham
Executive Director

Thursday, 28 November 1991

10.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited The Jean Tweed Treatment Centre, Toronto, Ontario

From The Jean Tweed Treatment Centre:

Jean Reay Day
Program Director

Thursday, 5 December 1991

10.00 a.m. The Committee resumed consideration of Section 3.13 of the Provincial Auditor's 1990 Annual Report relating to the OHIP Billings

The Committee visited The Renascent Centre, Toronto, Ontario

From The Renascent Centre:

John Campbell
President

Les Talbot
General Manager
Renascent Foundation

Bill Wilson
General Manager
Renascent Fellowship

Lucille Toth
Director
Development and Public Relations